your health
NETWORK
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Changes in Pharmacy Benefits for 2004

Prescription drugs continue to play an increasing role in the treatment of both acute and chronic disease. New drugs become available each year that are often significantly more costly than their predecessors. It also appears that Tennesseans spend more and utilize more prescription drugs per resident than any other state. A significant amount of this increase in utilization comes from drugs that are heavily marketed by the pharmacy companies.

Within all the plans sponsored by the State of Tennessee, $656.94 per member was paid during plan year 2002 for prescription drugs compared to $524.22 in 2001. This represents an increase of over 25 percent. In fact, plan costs for pharmacy benefits have been doubling every three years since 1994. The design of pharmacy benefits, whereby a member pays a fixed copayment, has insulated plan participants from these large increases in pharmacy costs.

To partially offset rising pharmacy costs and their impact on premium changes for plan year 2004, the Insurance Committees have modified the pharmacy benefits for all plan options. Effective January 2004, the PPO, POS and HMO options will have a three-tier benefit of

- $5 for generic
- $20 for preferred brand
- $40 for non-preferred brand drugs.

To encourage the use of generic drugs, the generic copay will remain at $5. Plan members are encouraged to ask their physician if a generic drug is appropriate for any prescribed medication. The use of generic drugs will save you and the plan significant money. Additionally, to ensure quality and performance, the U.S. Food and Drug Administration puts all generic drugs through a rigorous, multi-step approval process.

In addition to the pharmacy copay changes, beginning January 1, 2004, each health option will add a home delivery pharmacy program. This program will allow members to receive up to a 90 to 102 day supply of a given drug for one copay. However, members will no longer be able to receive a 90-day supply of a maintenance drug for one copay at a retail pharmacy unless the pharmacy has agreed to the same terms and conditions of the home delivery program.

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Changes in Pharmacy Benefits for 2004

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It is important to remember that all claims administrators have requirements for certain drugs concerning prior authorization as well as limitations on the amount of the drug that may be dispensed. The following includes general responses to questions regarding the new home delivery program. Members needing more specific information should consult their member handbook or contact the claims administrator for specific questions regarding plan policies and procedures.

Q. *Why is the state offering a home delivery option?*

A. Through BlueCross BlueShield, John Deere Health and Aetna, the state is offering a benefit enhancement to members with home delivery. This option gives members the convenience of having prescriptions delivered to their home, office or alternate address. This feature allows us to establish a lower price for providing the same prescription drugs. This saves the plan — and you — money.

Q. *Do some drugs still have limitations on the number I can receive?*

A. There are still quantity limitations on certain drugs and members should check with their claims administrator for specific information.

Q. *Do some drugs still require prior approval?*

A. Prior approval is still required on certain drugs and members should check with their claims administrator for prior approval requirements.

Q. *Will I be restricted on the types of drugs that I can receive through home delivery?*

A. In order to receive a prescription through the home delivery program, your physician must authorize a prescription that covers at least a 90-day period. Each of the claims administrators have some restrictions like prior authorization and quantity limitations on certain drugs. Members should consult the member handbook or contact the claims administrator for specific information.

Q. *How do I get started on the pharmacy home delivery program?*

A. Each of the claims administrators have specific instructions for using their home delivery program. Members should consult their member handbook or contact the claims administrator. Initially, it is suggested that you have your physician write a prescription for a 30-day supply while also authorizing a longer prescription for 90 to 102 days (depending on claims administrator). Prescriptions are usually received within 10-14 days from the time your order is mailed. Once you have started on home delivery, phone or internet can be utilized to fill the home delivery service orders. In most cases, you will need your ID number, prescription number and credit card to pay the copay. Orders mailed in can be paid by check or money order.

Q. *I received a flyer from my local pharmacy stating that it is unlawful for my health benefit insurer to require that I obtain my prescriptions via a mail order pharmacy. Is this true?*

A. We have been advised that the home delivery program is in compliance with Tennessee's Any Willing Pharmacy Law. The claims administrators mailed solicitations to retail pharmacists inviting them to participate in the home delivery program under the same terms and conditions as the home delivery providers. According to the claims administrators, no retail pharmacy agreed to the terms and conditions. The home delivery program is optional, not mandatory. You can choose to fill prescriptions through retail vs. home delivery, but home delivery is the only source for the 90 to 102 day supply for one copay.

Q. *What if I need the medication immediately?*

A. Have your physician write a prescription that you can have filled at your network pharmacy.

Q. *How can I get a prescription filled for beyond 90 days if I am going out of the country?*

A. The claims administrator's pharmacy manager will review each request separately. Specific information regarding the situation will have to be provided by the member or prescribing physician.

Q. *Do I have to be home when the prescription is delivered?*

A. In most cases, drugs are sent regular mail to the address you specify. There are cases, such as drugs requiring special handling, expensive drugs or controlled substances where a signature is required, and delivery cannot be to a post office box.

Q. *How do I contact the home delivery company?*

A. Members should consult their member handbook for specific information. Phone numbers and internet or e-mail addresses for the pharmacy managers are as follows:

- BlueCross BlueShield
  Advance PCS
  1.877.683.6837
  www.advancerx.com
- John Deere Health
  Wal-Mart Pharmacy
  1.800.273.3455
  email: wmsrx@wal-mart.com
- Aetna Rx Home Delivery
  1.866.201.3862
  TTY 1.800.201.9457
  www.aetnarxhomedelivery.com

notable

The waiver for out-of-network charges offered to BlueCross PPO participants by HCA only lasts until December 31, 2003. In addition to the required out-of-network coinsurance amount paid by the member, those members who utilize an HCA facility after the first of the year will be billed for the difference between the maximum allowable charge and the billed amount.

Always use participating network providers to receive maximum benefits. Participating network providers have agreed to accept the maximum allowable charge amount and write off the rest of the charge after applicable deductible, coinsurance, and copay amounts are paid by the member.

Effective January 1, 2004, the BlueCross Point of Service program will no longer require members to choose a primary care physician or obtain a referral prior to receiving care from a specialist. Members should choose participating Network S providers to receive maximum benefits.

The PPO and POS options offered by BlueCross allow for either a unique or continuous care exception for services not routinely available from a network provider. Exceptions are only granted for medical necessity and not convenience. When granted an exception, services are paid at the in-network level. However, charges exceeding the maximum allowable charge are still the responsibility of the member.

Late Applicant Process Continues for 2004

Under the 1996 Federal Health Insurance Portability and Accountability Act (HIPAA), group health plans must generally comply with the requirement of non-discrimination against individual participants and beneficiaries based on health status. However, the law also permits state and local government employers that sponsor health plans to elect to exempt a plan from these requirements for self-funded options. All of the state-sponsored health options are self-funded; therefore, the State of Tennessee has elected to exempt the plans from the prohibitions against discriminating against individuals and beneficiaries based on health status in order to allow medical underwriting through a late applicant process.

By requesting this exemption, the state-sponsored plans will be able to continue the process that allows an eligible individual, who is not presently enrolled (late applicant), to enroll in the plan through a medical underwriting or proof of insurability process. The exemption from this federal requirement will continue for the plan year beginning January 1, 2004, and ending December 31, 2004. The election may, but is not required to be, renewed for subsequent plan years.

Eligible employees may apply for coverage for themselves and/or their eligible dependents by submitting medical information about each applicant. Employee eligibility must be verified by the employing agency and a non-refundable application fee is required. Applications may be obtained from your agency insurance preparer or you may print a copy from our website at www.state.tn.us/finance/ins/.

This enrollment process is in addition to the special enrollment provision process for those who lose their health coverage due to a HIPAA qualifying event. Please see your *Insurance Handbook* for a list of qualifying events. In these instances, the medical underwriting process is not necessary. The special enrollment provisions require that application for coverage be made within 60 days of the qualifying event by submitting an *Application for Special Enrollment by Qualifying Event* and an *Enrollment/Change Application*. ■

Women's Health and Cancer Rights Act

Under the Women's Health and Cancer Rights Act of 1998, a group health plan participant who is receiving benefits in connection with a mastectomy is entitled to coverage for the following services:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Coverage for these benefits or services will be provided in a manner determined in consultation with the participant's attending physician.

Coverage for the mastectomy-related services or benefits required under the "Women's Health Act" will be subject to the same deductibles and coinsurance or co-payment provisions that apply with respect to other medical or surgical benefits provided.

If you have any questions about your healthcare option, please call the customer service number on your member identification card. ■

Prescription Drug Usage for 2002

During 2002, the state sponsored plans incurred charges for prescription drug payments in excess of $173 million on behalf of all plan participants. Additionally, plan participants paid $45 million in copayments.

A review of prescription drug usage by plan participants for 2002 shows the following pharmaceuticals as the top ten most utilized:

- Zocor (61,588 scripts filled)
- Zyrtec (57,215 scripts filled)
- Premarin (55,140 scripts filled)
- Lipitor (54,652 scripts filled)
- Allegra (49,342 scripts filled)
- Prilosec (47,369 scripts filled)
- Prevacid (45,978 scripts filled)
- Zoloft (45,877 scripts filled)
- Paxil (38,134 scripts filled)
- Vioxx (35,378 scripts filled)

Of these ten drugs, six fall under the categories of cholesterol lowering, antidepressants and anti-ulcer/heartburn. While these drugs are designed to treat different conditions, they all have two things in common: they are all in a higher-tiered copay level and they all have a less expensive generic or therapeutic alternative that could reduce your copay and plan benefit payments.

The charts provided here show the cost to the plan for these six drugs and outline the savings which could be realized if participants migrated to the generic or therapeutic alternative.

Some members may say, "why should I be concerned, this drug's copay is only a little higher to me and I don't care what the plan has to pay." But remember, the cost of these drugs is paid from premiums paid by you and your employer. Any savings to the plan becomes a savings to you as well. Ask your physician if one of these alternative drugs is appropriate for you. ■

CHOLESTEROL LOWERING

Prescribed Drug	Cost per Day	Plan Cost per Script	Number of Scripts	Net Payments by Plan
Zocor (#1)	$3.09	$104.53	61,588	$6,437,497.78
Lipitor (#4)	$2.26	$100.39	54,652	$5,486,408.69

Alternative Drug	Cost per Day	Annual Savings with a Migration of 10%	25%	50%
Lovastatin	$1.94	$315,620	$789,050	$1,578,100

ANTI-ULCER/HEARTBURN

Prescribed Drug	Cost per Day	Plan Cost per Script	Number of Scripts	Net Payments by Plan
Prilosec (#6)	$4.13	$123.36	47,369	$5,843,531.21
Prevacid (#7)	$3.82	$115.75	45,978	$5,321,734.61

Alternative Drug	Cost per Day	Annual Savings with a Migration of 10%	25%	50%
cimetidine	$0.41	$1,002,615	$2,506,536	$5,013,073

ANTIDEPRESSANTS

Prescribed Drug	Cost per Day	Plan Cost per Script	Number of Scripts	Net Payments by Plan
Zoloft (#8)	$2.00	$59.99	45,877	$2,752,168.69
Paxil (#9)	$2.22	$67.38	38,134	$2,529,315.72

Alternative Drug	Cost per Day	Annual Savings with a Migration of 10%	25%	50%
fluoxetine	$1.40	$175,946	$439,864	$879,728

Q How do I weather winter illness?

A No matter how healthy you are, most of us do not escape a cold or the occasional bout of flu. Consider getting a flu shot this year. To prevent colds, wash your hands. Colds and flu are caused by getting the virus from another person. Avoid touching your nose, mouth or eyes with your hands between washings.

If you get a cold or flu:

- Get plenty of rest.
- Drink plenty of fluids — water flushes your system, washing out the poisons.
- Take aspirin (give only acetaminophen to children) or decongestants if they make you feel better.
- Use a humidifier to combat stuffiness and dry cough.
- Antibiotics are useless in treating viral infections, such as colds and flu.

Foods to eat when battling a cold or flu:

- Bananas: Soothe upset stomachs.
- Bell Peppers: Loaded with vitamin C.
- Blueberries: Curbs diarrhea, high in natural aspirin.
- Carrots: Loaded with beta-carotene.
- Chili Peppers: Can open sinuses and help break up mucus in the lungs.
- Cranberries: Help prevent bacteria from sticking to cells lining the bladder and urinary tract.
- Mustard and Horseradish: Helps break up mucus in air passages.
- Onion: Purported to help the body clear bronchitis and other infections.
- Rice: Curbs diarrhea.
- Tea: Black and green tea (not herbals) purported to have natural antibiotic and anti-diarrhea effects.

Identification Cards to be Reissued

All health insurance companies will reissue identification cards to plan members during December. New cards are necessary due to the changes in prescription drug copayments and new copayments for physician services. New cards should be carried with you and shared with providers as you seek medical care in 2004. Old cards should be destroyed.

BlueCross POS Participants

BlueCross Point of Service participants will notice that their cards will have a new "PPO in a suitcase" logo printed on the card. Please be advised, this does not mean that your coverage has been transferred to the PPO. Beneath the logo, it will clearly state "POS Plan — State of Tennessee." The purpose of the logo is to identify you as a member of the BlueCard PPO program. This program links together PPO network providers from Blue Plans across the U.S. and allows you, as a POS participant, access to a nationwide network of providers even while traveling outside the Blue Network S service area. By using the BlueCard PPO program, your standard POS benefit structure is available nationwide while traveling on business or pleasure. To find a BlueCard PPO provider outside of Tennessee, call 1.800.810.blue (2583) or visit www.bcbst.com on the web. ■

Benefit Changes

During this year's annual transfer period, participants were provided with information on benefit changes which will be effective for 2004. For all healthcare options, the Insurance Committees adopted a balanced approach of moderate premium increases and benefit changes. This approach places more of the cost of healthcare services on the participant in the form of slight increases in deductibles and copays rather than leaving benefits constant and increasing premiums even more for all participants, regardless of the number of services they use.

The benefit changes are intended to mitigate increasing benefit costs which are anticipated to grow by 15 percent during 2004. The benefit changes and premium increases are attributable to increasing payments by the plans for medical services provided to members. The factors contributing to this continued level of growth include:

- Pharmacy costs which increase by about 25 percent each year.
- Increases in the usage and cost of outpatient services.
- Older workers and retirees are an increasing portion of plan membership and the older the individual, the higher the average benefit payments.
- Despite premium increases, the plans have experienced significant losses over the past few years as claims payments exceed the amount of premium collected.

Please be aware that all healthcare options are self-insured. This means that claims payments are made from the money collected in premiums — including employer contributions and employee deductions — with only a small percentage provided to the insurance companies for administrative services and claims processing. Therefore, be a wise consumer and use your medical benefits wisely. Any reductions in utilization and cost (such as using generic drugs when appropriate, only using the emergency room for emergencies and improving your health through preventative care) would be realized by all members in the form of smaller premium increases necessary to fund the plans. ■

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N E T W O R K

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